



Welcome to your new Flex Spending Account Plan Year!

We feel that you will find our website a useful tool. By logging into your account you will be able to monitor your reimbursement account activity and fund balance, file claims on line and access forms and other information. To log into your account, please follow the instructions found on the next page of this document.

HOW TO ACCESS YOUR FLEX SPENDING ACCOUNT FUNDS:

1. **FlexExpress© Card Users** – If you requested a new *FlexExpress* card you will be receiving it at your home address in a plain white envelope. If you re-activated your current *FlexExpress* card(s), it has been updated with your new election.

Remember, you may only use the card at qualified providers of health care services or products. Also, IRS regulations state you **must** retain documentation for every transaction. Benefit Strategies reserves the right to ask for documentation to verify any expenses paid with your *FlexExpress* Card. If your *FlexExpress* Card is lost or stolen, please notify us immediately.

2. **Enter Your Reimbursement Request On Line** – Log in to your account (Instructions follow), click **File Claims** and follow the instructions. Print the Confirmation page and mail it or fax it in with your receipts. Try it – it's easy!
3. **Submit a Request For Reimbursement via Fax or Mail** – A copy of a Request for Reimbursement form and directions is attached with this notice. Additional forms may be obtained from your employer or from Benefit Strategies' website: www.benstrat.com under "Available Forms." Fax or mail the completed form along with documentation of your eligible expenses to Benefit Strategies. Properly completed claims are usually processed within 1 week. You may submit claims as often as you like. Do make sure, however, that the expense you are requesting reimbursement for is eligible according to IRS guidelines and that it will not be reimbursed by your insurance or any other source.

Do you have questions? Contact Benefit Strategies!

Mailing Address:

PO Box 1300
Manchester, NH 03105-1300

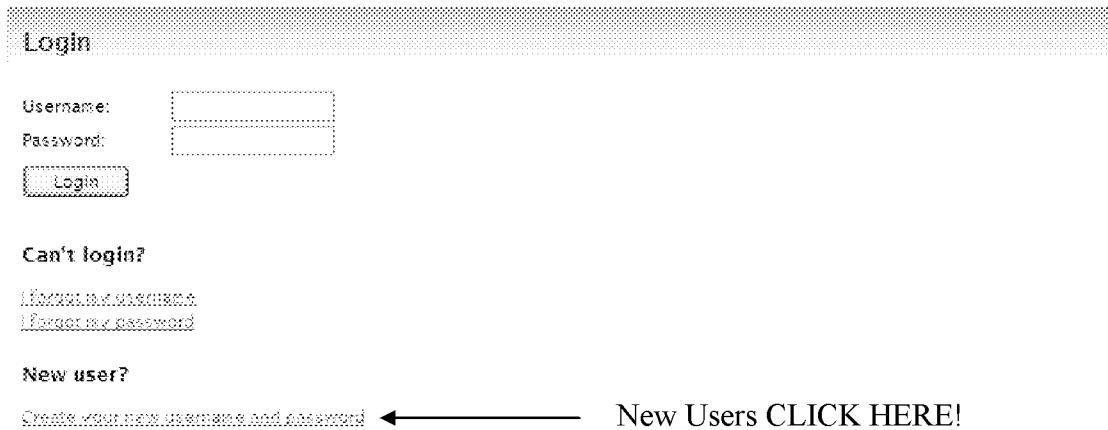
Telephone: (888) 401-FLEX (3539)

FAX: (603) 647-4668

e-mail: claimsupport@benstrat.com

WEB-SITE LOG IN INSTRUCTIONS:

1. Open your browser (e.g. Internet Explorer) and log into our website: www.benstrat.com . Click on **Flexible Spending Participant Login**.



The image shows a 'Login' screen with fields for 'Username' and 'Password', a 'Login' button, and links for 'Can't login?' and 'Forgot my password?'. Below these, there is a section for new users with a link 'Create your new username and password' and a large arrow pointing to the right with the text 'New Users CLICK HERE!'. The background has a subtle grid pattern.

2. **First time Users:** Click on “Create your new username and password” to create your new account.

OR

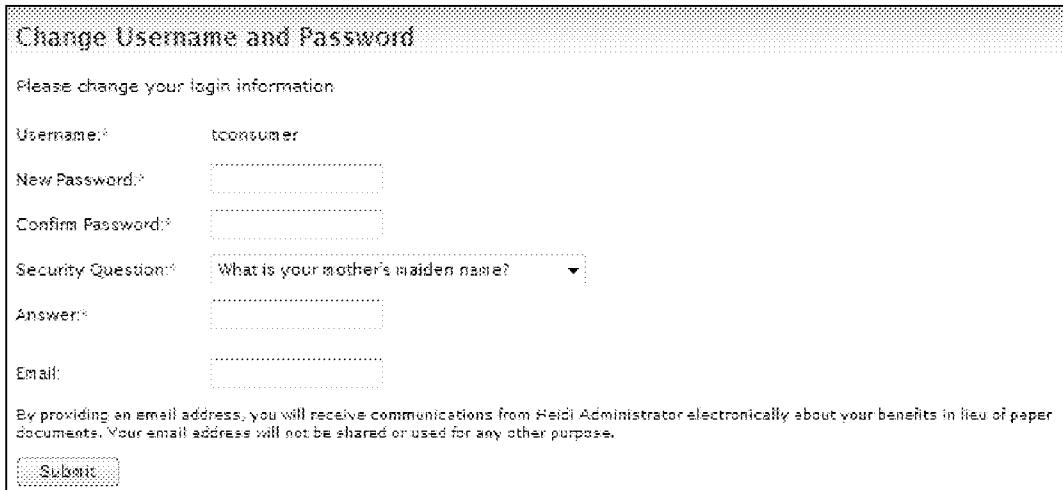
3. **Log in using the following:**

USERNAME: Your username will be your *first name initial* followed by your *entire last name* and the *last four digits of your social security number*

Example: Jason Smith, SSN: 121-22-3456.
Username: jsmith3456.

PASSWORD: *changeme*

If this is your first time logging in to our enhanced web-site, use *changeme* as your password. You will then be instructed to create a new and unique password.



The image shows a 'Change Username and Password' form. It includes fields for 'Username' (toconsumer), 'New Password', 'Confirm Password', 'Security Question' (What is your mother's maiden name), 'Answer', and 'Email'. A note at the bottom states: 'By providing an email address, you will receive communications from Heidi Administrator electronically about your benefits in lieu of paper documents. Your email address will not be shared or used for any other purpose.' A 'Submit' button is at the bottom.

The password must:

- Have a minimum of 6 characters
- Not be one of your last 3 passwords
- Contain upper and lower case letters
- Contain at least one number

Once you have successfully logged in, you will see a screen that looks like this. From here, you may click on items to file a claim, check your real-time account balance and payment history, or get plan information or forms.

| | | | | | | |
|---|-----------------------|-------------------------------|---------------|-------|-------|----------------------|
| HOME | ACCOUNTS | PROFILE | NOTIFICATIONS | FORMS | LINKS | Test Consumer Logout |
| Welcome, Test | | | | | | |
| Welcome to your single source for all you need to know about your pre-tax benefits. Request payment, check payment status, view account balance and summary information, access important notifications about your account, and more! | | | | | | |
| It's Annual Enrollment Time This is your chance to enroll in your pre-tax benefits for the upcoming plan year. These benefits allow you to save federal, state, social security and Medicare taxes on dollars you put into the account. Simply click on the "Enroll" button to begin the process to saving money. | | | | | | |
| Plan Year | Enrollment Period | Accounts | Actions | | | |
| 2010 Plan Year | 9/27/2009 - 12/5/2009 | Med Flex Spending Acct HRA | Enroll | | | |

HOW TO FILE YOUR CLAIMS ONLINE

1. Click on the Accounts Tab and choose File Claims or click File Claims under the Action column of the account you wish to file claims against.

| | | | | | | |
|--|--|--------------------------------------|-------------------------------|-------|-------|--|
| HOME | ACCOUNTS | PROFILE | NOTIFICATIONS | FORMS | LINKS | Ted Smith Logout |
| Welcome Welcome, payment and more | | | | | | |
| Account Summary File Claims Payment History Election Summary Plan Descriptions | | | | | | |
| a need to know about your pre-tax benefits. Request payment, check payment status, view account balance and summary information, access important notifications about your account, and more! | | | | | | |
| ACCOUNTS | | | | | | View Account Summary |
| Account | Available Balance | | | | | Actions |
| HRA | \$130.12 | | | | | File Claim View Claim History |
| Questions? Contact Consumer Support at: (123) 123-1234 ext. 1234 Or toll free at: (800) 800-8008 ext. 8008 or Technicalsecure@lennarhome.com . | | | | | | |
| Accounts | Profile | Notifications | Forms | | | |
| Account Summary Account Activity File Claims Payment History Election Summary Plan Descriptions | Profile Summary Login Information | Notification History | Request Forms | | | |

2. Enter the information for each expense, clicking submit between each one. Make sure you have valid receipt(s) for your expenses, as you will need to fax or mail them to Benefit Strategies.

| | | | | | | |
|--|----------|---------|---------------|-------|-------|---|
| HOME | ACCOUNTS | PROFILE | NOTIFICATIONS | FORMS | LINKS | Ted Smith Logout |
| File Claim: HRA | | | | | | Claims Basket (0) |
| <p>Please enter your claim amount information below. If all or part of your claim is unreimbursable due to auditing factors (i.e. claim exceeds available balance in your account), then you will only be reimbursed the approved amount. If this occurs, you will receive notification in the mail.</p> <p>Do you have a valid receipt for this product/service? <input checked="" type="radio"/> Yes <input type="radio"/> No What is a valid receipt?</p> <p>Date of Service: <input style="width: 150px; border: 1px solid #ccc; border-radius: 5px; padding: 2px 5px;" type="text" value="09/26/2009"/> (mm/dd/yyyy)</p> <p>Please choose the category and type of product/service that best describes your claim. If you choose "Other" or "Over-the-Counter Drugs," you must provide a description below.</p> <p>Category: <input style="width: 150px; border: 1px solid #ccc; border-radius: 5px; padding: 2px 5px;" type="text" value="Choose from list..."/> X</p> <p>Type of Product/Service: <input style="width: 150px; border: 1px solid #ccc; border-radius: 5px; padding: 2px 5px;" type="text" value="Choose from list..."/> X</p> <p>Product/Service Description: <input style="width: 300px; border: 1px solid #ccc; border-radius: 5px; padding: 2px 5px;" type="text"/></p> <p>Product/Service Provider: <input style="width: 150px; border: 1px solid #ccc; border-radius: 5px; padding: 2px 5px;" type="text"/></p> <p>Person receiving Product/Service: <input checked="" type="radio"/> Ted Smith</p> <p>Claim Amount: <input style="width: 100px; border: 1px solid #ccc; border-radius: 5px; padding: 2px 5px;" type="text" value="0"/> \$</p> <p>Did you drive to receive this product/service? <input checked="" type="radio"/> Yes <input type="radio"/> No Claiming Mileage <i>You may claim mileage expense for reimbursement.</i></p> <p>Number of Miles: <input style="width: 100px; border: 1px solid #ccc; border-radius: 5px; padding: 2px 5px;" type="text"/></p> <p>Mileage Reimbursement:</p> <p>Total Claim Amount:</p> <p><input style="width: 150px; border: 1px solid #ccc; border-radius: 5px; padding: 2px 5px;" type="button" value="Calculate Total"/></p> <p style="text-align: center; margin-top: 20px;"> <input style="border: 1px solid #ccc; border-radius: 5px; padding: 2px 10px;" type="button" value="Submit"/> <input style="border: 1px solid #ccc; border-radius: 5px; padding: 2px 10px;" type="button" value="Cancel"/> </p> | | | | | | |

3. If you have more than one expense to request reimbursement for, click on **File a New Claim**. Enter information and click **Submit**.

Claims Basket

[Claims Basket \(1\)](#)

[File New Claim](#)

| Date of Service | Plan | Type of Product/Service | Provider | Claim Amount | Approved Amount* | Remove |
|-----------------|---------------|-------------------------|---------------|--------------|------------------|------------------------|
| Update 9/5/2008 | HRA w/ER Cont | Dental Copay | Dental Office | \$15.00 | \$15.00 | Remove |
| | | | | Total | \$15.00 | \$15.00 |

* The approved claim amount will be reimbursed based on your available balance. If a plan requires funds to be contributed prior to the reimbursement of claims, you will be reimbursed as funds become available in your plan account.

Terms and Conditions

I have read and agree to the [Terms and Conditions](#).

You must choose to **SUBMIT** this basket in order to send these claims for processing.

[Submit](#) [Cancel](#)

 [Questions?](#)
Contact Consumer Support at: (123) 123-1234 ext. 1234 Or toll free at: (800) 800-8008 ext. 8008 or TechnicalSupport@HealthPlan.com.

Accounts **Profile** **Notifications** **Forms**

[Account Summary](#) [Profile Summary](#) [Notification History](#)

[Account Activity](#) [Login Information](#)

[File Claims](#)

[Payment History](#)

[Election Summary](#)

[Plan Descriptions](#)

4. Once all claims are entered, you must:

- 1) Agree to the **Terms & Conditions** (click on appropriate box) and
- 2) Commit the claim(s) by clicking **Submit**.

5. PRINT AND SEND CONFIRMATION WITH RECEIPTS!

A Confirmation Page that looks like this will come up. The confirmation page verifies that all claims have been successfully submitted! You must print this page by clicking **Print Confirmation** and mail it along with your receipts to:

Benefit Strategies
PO Box 1300
Manchester, NH 03105-1300

Or FAX to: (603) 647-4668

| HOME | ACCOUNTS | PROFILE | NOTIFICATIONS | FORMS | LINKS | Ted Smith Logout | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|----------------|----------------|------------------|---------------------|------|-----------------|----------------|----------------|------------------|------------------|-------------------|-----|----------|---------|--------|---------|-----|--|--|--|---------|--------|---------|--|--|
| Claim Confirmation | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Ted Smith tedsmith | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| You have successfully filed the claim(s) listed below. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| You can expect deposit of approved amounts in your accounts of record in accordance with your employer's reimbursement schedule, subject to the following guidelines: - Substantiation may be required before the associated claims may be paid to your account of record, if this claim is subject to further auditing, you will be contacted. - If this claim exceeds your available balance, only available funds will be reimbursed. Required Receipt(s) must be received within 45 days. If we do not receive the receipt(s) by this date, your reimbursement will have to be paid back in to the appropriate account. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Receipt(s) Required - Print this Page: Print this confirmation, attach the required receipts and fax or mail to Test TPA at one of the contacts listed below. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Fax: (603) 647-4668 Mail: 123 Main St Building 123 Suite 123 Minneapolis, MN 55555 Email: tedsmith@benefitstrategies.com | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| If you are unable to print this confirmation: Send your receipts with a note that includes (a) the name of the company you work for, (b) your name, and (c) the claim numbers listed below. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <table border="1"><thead><tr><th>Claim Number</th><th>Plan</th><th>Date of Service</th><th>Receipt Amount</th><th>Mileage Amount</th><th>Approved Amount*</th><th>Receipt Required</th></tr></thead><tbody><tr><td>WMC090928P0000501</td><td>HRA</td><td>9/5/2009</td><td>\$15.00</td><td>\$0.00</td><td>\$15.00</td><td>Yes</td></tr><tr><td></td><td></td><td></td><td>\$15.00</td><td>\$0.00</td><td>\$15.00</td><td></td></tr></tbody></table> | | | | | | Claim Number | Plan | Date of Service | Receipt Amount | Mileage Amount | Approved Amount* | Receipt Required | WMC090928P0000501 | HRA | 9/5/2009 | \$15.00 | \$0.00 | \$15.00 | Yes | | | | \$15.00 | \$0.00 | \$15.00 | | |
| Claim Number | Plan | Date of Service | Receipt Amount | Mileage Amount | Approved Amount* | Receipt Required | | | | | | | | | | | | | | | | | | | | | |
| WMC090928P0000501 | HRA | 9/5/2009 | \$15.00 | \$0.00 | \$15.00 | Yes | | | | | | | | | | | | | | | | | | | | | |
| | | | \$15.00 | \$0.00 | \$15.00 | | | | | | | | | | | | | | | | | | | | | | |
| * The approved claim amount will be reimbursed based on your available balance. If a plan requires funds to be contributed prior to the reimbursement of claims, you will be reimbursed as funds become available in your plan account. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Please send in the Required Receipt(s) listed above within 3 days. If we do not receive the receipt/s by this date, your reimbursement will be denied. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Remember, regardless of which receipt(s) you are required to submit, you are responsible for retaining a copy of all receipts for three years in the event you or your Pre-tax Account plan are audited by the IRS. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| <input type="button" value="Print Confirmation"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Trouble printing your confirmation? Get latest version of Adobe Reader at http://www.adobe.com or print from your browser by selecting File / Print in your browser menu. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  Questions? Contact Consumer Support at: (123) 123-1234 ext. 1234 Or toll free at: (800) 800-8008 ext. 8008 or www.benefitstrategies.com | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Accounts Account Summary Account Activity File Claims Receipts Needed Payment History Statement Summary Plan Descriptions | Profile Profile Summary Login Information | Notifications Notification History | Forms | | | | | | | | | | | | | | | | | | | | | | | | |

IMPORTANT NOTES ON FILING CLAIMS

- 1) Paper Request for Reimbursement Forms must be filled out **COMPLETELY** and signed. Medical expenses must FIRST be submitted to your insurance provider. Only out-of-pocket expenses incurred during your active participation in the plan year are reimbursable. (Incomplete forms **will be** returned.)
- 2) Mail or FAX form and copies of receipts to Benefit Strategies at the following address:

Benefit Strategies, LLC
PO Box 1300
Manchester, NH 03105-1300
Fax: (603) 647-4668

- 3) Complete claims received by NOON on Thursday will usually process for reimbursement on Monday. **Does not apply to all clients.*
- 4) Copies of all third party documentation for expenses you are claiming should be submitted on **8 1/2 by 11 paper along with** your **COMPLETED Reimbursement Request**. *Please keep original receipts for your tax records.*
- 5) Documentation must clearly show the following:.
 - a. the **date** the expense was **incurred** (NOT the date paid)
 - b. the **provider** of services,
 - c. a **description of the service** and/or expense, and
 - d. the **charge** for each service and amount paid or denied by insurance.

Health Care Reimbursement Account documentation can include statements, itemized bills, and/or insurance “Explanation of Benefits” forms. ***Note: Canceled checks, credit card receipts, and balance forward statements are NOT acceptable documentation.***

Dependent Care Reimbursement Account documentation must show the dates of service, provider’s name, and dependent’s name. Section 4 of the Request For Reimbursement form may be used as eligible documentation. You must have on file the Taxpayer ID Number or Social Security Number of your Dependent Care providers. You will need to provide these numbers to the IRS when filing your taxes.

We hope you will find this overview helpful in getting starting with the new plan year. If you have any questions, please contact our office at (888) 401-3539. A member of our client relations team will be glad to help you. (603) 647-4666. One of our operators will direct you to someone who can help you.

Thank you!